

Ethical Guidelines for Counselors Working With Older Adults

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Counselors working with older adults may encounter situations that are not directly addressed by the ethical standards of the American Counseling Association (1995). After an extensive review of the literature, the Standards Committee of the Association for Adult Development and Aging (1998) identified 3 areas of concern: older adults with cognitive impairments, older adults who are the victims of abuse, and older adults with a terminal illness. This article examines the unique needs of older adults with these concerns and proposes guidelines for counselors working with such clients.

Demographic data indicate that the population of adults ages 65 and older is growing at an increasing rate. By 2030, there will be about 70 million older adults, more than twice their number in 1997. People 65 and older are projected to represent 13% of population in the year 2000 but will be 20% by 2030 (Administration on Aging, 1998). As the number of older adults in the population continues to grow, counselors will increasingly be faced with meeting the needs of older adults and their families. Although the ethical standards of the American Counseling Association (ACA, 1995) guide the practice of counseling, counselors working with older adults may encounter situations that are not directly addressed, or are inadequately addressed, by these standards. After an extensive review of the literature, the Standards Committee of the Association for Adult Development and Aging (AADA) identified three areas of concern: older adults who are cognitively impaired, older adults who are the victims of abuse, and older adults who are terminally ill (Association for Adult Development and Aging, 1998). Note that although these areas of concern were identified as creating ethical dilemmas, few articles were found that actually attempted to address these issues. When articles were found, the subject matter addressed included primarily ethical considerations related to research involving older adults with cognitive impairments. This article examines the unique needs of these adults and proposes guidelines for counselors working with clients in these three areas.

DECISION-MAKING MODEL

It is important to realize that no set of ethical standards can cover every situation that may arise. As stated previously, three such situations, which are not specifically addressed by ACA ethical standards, may arise when counselors are working with older adults. If counselors are to make appropriate ethical decisions regarding the treatment of older adults in each of these situations, it is important for them to be familiar with models for ethical decision making. Fitting (1986) proposed a model of principle ethics that includes three ethical principles to guide decision making. *Principle ethics* are a set of prima facie obligations one considers when confronted with an ethical dilemma. Fitting's model includes the principles of *fidelity*, *autonomy*, and *beneficence*. Fidelity is the ethical principle that addresses the quality of the relationship between the counselor and the client. It implies that essential elements of the counseling relationship include trust and loyalty. In short, it addresses the question of who the client is and whose side the counselor is ultimately on.

The second principle, autonomy, refers to the right of older adults to make their own choices and decisions regarding matters that affect their lives. This principle implies that counselors must respect their clients' choices and not attempt to force their own values on the client. It further implies that counselors should always seek input on decisions that affect the client, even when the client may have an impairment. That is to say, even when a client has a cog-

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nitive impairment and is unable to make decisions in a totally autonomous capacity, the counselor should always attempt to involve the client, to the extent possible, in the decision (Fitting, 1986; Myers & Schwiebert, 1996).

Finally, the concept of beneficence dictates that the counselor actively work to prevent harm and work toward positive outcomes for the client. Although it is often difficult to ascertain which solution is ultimately most likely to benefit the client, it is incumbent on the counselor to continually strive to keep the client's best interest in the forefront as decisions are evaluated (Fitting, 1986; Myers & Schwiebert, 1996).

An examination of the overall guiding principles found in ethical codes of the helping professions (American Counseling Association's [1995] *Code of Ethics and Standards of Practice*, the American Medical Association's [1986] *Principles of Medical Ethics*, the American Psychiatric Association's [1986] *Principles of Medical Ethics*, the American Psychological Association's [1981] *Ethical Principles of Psychologists*, the Commission on Rehabilitation Counselor Certification's [1987] *Code of Ethics*, the National Board of Certified Counselors' [1997] *Ethical Guidelines for Counselors*) has yielded three common principles that are closely correlated with Fitting's model. Ethical principles that exist across disciplines are founded on the premise that the helper do no harm to the client and that the helper provide treatment that is in the client's best interest and that promotes client dignity. Two additional principles exist: intervening (a) when a client is a danger to himself or herself and (b) when the client is a danger to another person (Doolittle & Herrick, 1992). Thus, the concepts of beneficence, fidelity, and autonomy are supported across the ethical guidelines of many helping professions. The following discussion of three populations of older adults for whom ACA's ethical standards are inadequate will therefore be based on the three principles of Fitting's (1986) model.

In addition to models of principle ethics, *virtue ethics* must be considered. Virtue ethics complement models of principle ethics and focus on character traits and nonobligatory ideals that facilitate the development of ethical individuals. Virtue ethics address the issue of how an individual chooses which principles apply to a situation and which principles to follow when two or more principles are in conflict. Because even well-trained, well-intentioned individuals may disagree on which principle(s) may be most important in any given situation, the individual must choose which principle he or she considers most important. Virtue ethics address the process by which the individual makes this choice based on his or her own morals and values (Meara, Schmidt, & Day, 1996). Therefore, the following discussion of the three populations of older adults for whom ACA's ethical standards are inadequate will also be guided by the concept that although the individual may apply principle ethics to the situation, virtue ethics also play an important role in explaining why an individual chooses the principles he or she ultimately applies.

OLDER ADULTS WITH COGNITIVE IMPAIRMENTS

Current ACA (1995) ethical standards do not provide adequate guidelines for working with older adults who have cognitive impairments. More specifically, the informed consent standards seem inadequate. The ACA standards state that a guardian or other appointed legal representative can give consent for a person unable to give such consent himself or herself. The question then becomes when is a person unable to give such consent. This may be an even more complex question when a progressively deteriorating mental condition, such as Alzheimer's disease, is present. The counselor may begin working with the client during the beginning stages of such a disease, and as the disease progresses, it may no longer be clear that the individual can give truly informed consent to remain in therapy (Myers & Schwiebert, 1996; Netting & Williams, 1989). In this case, it is important that the counselor be familiar with screening instruments such as the Mini Mental Status Exam (Folstein, 1998) and other measures of cognitive impairment. The counselor must also know the limitations of the instruments when working with older adults.

Another dilemma might be the client's inability to remain in a safe, independent living environment due to his or her deteriorating condition despite his or her wishes to remain in that environment. Other mental conditions may cause intermittent periods of confusion and disorientation that would impede a client's consistent ability to give informed consent or make sound decisions. (Myers & Schwiebert, 1996). These dilemmas raise questions such as the following: Does this mean the counselor can no longer treat the client? Does the counselor need to wait until a legal guardian has been appointed for the client before they can begin providing services? Does the counselor have the obligation to initiate steps to move the client to more supportive housing when it is clear the client can no longer remain in an independent living situation safely, despite his or her wishes to do so?

In addition to the client being a danger to himself or herself, issues may arise when the counselor must evaluate if the client is a danger to others. If a client has a cognitive impairment and the counselor believes he or she is a danger to others when driving, what is the counselor's obligation? If an older person has a cognitive impairment and is caring for a bedridden spouse, is the individual a danger to that person if he or she can no longer remember to do such tasks as turning off the stove? The counselor must make ethical judgments about maximizing independence (autonomy) while preventing harm (beneficence).

CASE EXAMPLE

An older person with advanced Alzheimer's lives alone in the family home. Her children have come to visit and report to the counselor that their mother has begun to forget to turn the stove off, has left water running, and has been found wandering outside in the neighborhood in a disoriented state several times. They believe she

should be placed in a nursing home for her safety. The mother has refused and states she would rather die than move to a "home." When the counselor talks with the mother, she seems to be able to actively engage in appropriate conversations but forgets many common facts such as the names of her grandchildren and speaks as if her dead husband were still alive. The client admits forgetting "small things" but states that is expected as one grows older. She is adamant about staying in her home and will not consider moving to a nursing home.

On the basis of the ethical guidelines just discussed, what is the counselor's obligation? First, the client's best interest must be maintained. Therefore, the counselor must first determine if, in fact, the client has a progressively deteriorating condition that cannot be expected to improve with treatment. A thorough and accurate geriatric assessment by a qualified physician is the first step in this process. Once a medical diagnosis of advanced Alzheimer's disease has been made, the counselor's interventions must be guided by the ethical principles that the client's best interest is to be maintained and that the client is not a harm to herself. This may involve discussions with the client and family members as to what is best for all involved. The counselor can then facilitate appropriate decision making that maintains, to the extent possible, the rights and dignity of all individuals involved (Doolittle & Herrick, 1992; Myers & Schwiebert, 1996).

Another ethical dilemma that counselors may encounter when conducting research involving older adults with cognitive impairments is the need to obtain informed consent for participation in the research (Vonthron Good & Rodrigues-Fisher, 1993). An easy answer to this dilemma may seem to be excluding clients with cognitive impairments from research studies. This seemingly straightforward answer is complicated by the fact that without research it may be impossible to find effective treatment strategies for their particular impairment, thus limiting the clients' rights to options that may be in their best interest. Counselors who are conducting studies that potentially involve clients with cognitive impairments must be guided by the principles of maintaining client dignity and doing no harm to the client (Milliken, 1993). Steps to help ensure that the best interests of the clients are maintained include a clear statement and understanding of the research and the potential benefits and dangers associated with it. Second, an independent review board of individuals knowledgeable about the fields of research and the older population should thoroughly examine the research and its potential benefits and liabilities to determine if the risks outweigh the benefits for older adults and how the potential risks may be minimized. Finally, the counselor engaged in research with older adults who have cognitive impairments must realize that, ultimately, the best safeguard for the client is a competent, informed, and compassionate counselor (Milliken, 1993; Netting & Williams, 1989; Ochroch, 1990).

OLDER ADULTS WHO ARE THE VICTIMS OF ABUSE

Another issue that is not adequately addressed in the ACA (1995) *Code of Ethics* is elder abuse. Although not restricted to the family, violence against older adults most often occurs in a family setting and is often unreported. Pillemer and Finklehor (1988) estimated that only 1 in 14 cases of elder abuse are reported, compared with 1 in 6 cases of child abuse. Griffin and Williams (1992) reviewed the literature on elder abuse and concluded that between 4% and 7% of older adults living with family members are abused, numbering more than 10,000,000 older adults per year. They noted that differences in the meaning of abuse among different groups results in different estimates of prevalence. Definitions may vary across cultural, ethnic, and religious groups (Anetzberger, Korbin, & Tomita, 1996), and across all of these groups by geographic location. They vary across states and legal jurisdictions as well. Wolf (1997) noted that the literature contains little data on the consequences of elder abuse for abused older adults but that clinical reports have documented severe emotional distress and increased mortality are frequent outcomes.

The American Medical Association (1990) defined *elder abuse* to mean

an act or omission which results in harm or threatened harm to the health or welfare of an elderly person. Abuse includes intentional infliction of physical or mental injury, sexual abuse, or withholding of necessary food, clothing, or medical care to meet the physical and mental health needs of an elderly person by one having the care, custody, or responsibility of an elderly person. (p. 2460)

Wolf, Godkin, and Pillemer (1984) defined four categories of elder abuse: physical abuse, psychological abuse or chronic verbal aggression, material abuse or financial exploitation, and violation of rights. Other authors have expanded this typology to include neglect, both intentional or unintentional (Vida, 1994).

Physical abuse includes any violent behavior that results in bodily harm, such as hitting, kicking, biting, choking, burning, striking with objects, and pulling hair (Utech & Garrett, 1992), unreasonable restraint, and forcing the older person to ingest a substance, such as psychotropic medications (Ramsey-Kwalick, 1993). Psychological abuse includes making demeaning, infantilizing, or insulting statements, and threatening such acts as institutionalization or abandonment (Lachs & Pillemer, 1995). Fears of isolation or abandonment are common in response to such abuse (Valentine & Cash, 1994). Financial exploitation refers to the confiscation of funds or material resources of an older person when used for purposes other than the older individual's welfare (Ramsey-Kwalick, 1993). Neglect refers to withholding necessary care, as well as careless conduct and acts of omission regarding the needs of the older person for care. Self-neglect is included in this definition (Lachs & Pillemer, 1995). The most prevalent type of abuse is physical abuse, followed by habitual verbal aggression and then neglect.

Although any older person is a potential victim of abuse, women are most at risk (National Center on Elder Abuse at The American Public Human Services Association, 1998). Older adults in poor health are three to four times more likely to be abused, particularly if they experience organic brain disorders (Pillemer & Finklehor, 1988). Resentment created in caretakers of dependent older adults is the most commonly cited factor predisposing older adults to abuse (Kosberg, 1988). The typical abused older person is female, Caucasian, 75 years of age or older, middle class, has a severe mental or physical impairment, and resides with the perpetrator. The typical perpetrator is female, Caucasian, middle-aged, is sharing a common residence with the older person, is most likely a daughter, and is experiencing other conflicts and both internal and external life stressors (Myers & Shelton, 1987; National Center on Elder Abuse at The American Public Human Services Association, 1998). Some older adults may be simultaneously both abusers and abused (Utech & Garrett, 1992).

Counselors working with older adults need to be familiar with the signs of each type of abuse, the risk factors previously described, and a variety of correlates of abuse that may be important in assessing abusive or potentially abusive situations. These correlates include factors in the individual older adult, relationships between older adults and their caregivers, situational factors, and sociocultural factors (Henton, Gate, & Emery, 1984). Older adults who perceive themselves as helpless and dependent, who have low self-esteem, and who lack assertive behaviors are most at risk. Poor premorbid relationships between older adults and their caregivers are predisposing factors, as are caregiver characteristics such as psychopathology, psychiatric illness, substance abuse, depression, and personality disorders. Verbal or physical abuse by the older adult with an impairment toward the caregiver and caregiver perceptions of burden and lack of support or help are additional factors predisposing an older person to abuse (Compton & Flanagan, 1997). The greater the amount of time spent with an older person who is mentally or physically ill, the greater the potential for abuse; hence caregivers living with dependent older adults are most likely to be abusers. Societal attitudes that demean older adults, ageism, racism, sexism, unemployment, and violence as a way of life contribute to abusive situations.

The ethical principals of ensuring that the best interests of clients are served dictate that counselors assess for potential abuse and intervene where abuse is likely to occur or is suspected to have occurred. Maltreatment of an older person is seldom an isolated event and frequently multiple forms of abuse occur simultaneously. A pattern of recurring abuse over a period of time is the most likely scenario (Special Committee on Aging, 1983). Accurate assessment is extremely difficult and should include the nature and severity of the abuse, the older adult's past life history and current personal and social coping resources, and his or her social support system (Stewart & Robinson, 1996). Although most states have mandatory reporting laws for el-

der abuse (Macolini, 1995), health and social service care providers are often not trained to recognize signs of elder abuse. The older person may not want the counselor to report the abuse or intervene, particularly if the abuser is an adult child, for fear of retribution from the caregiver or, worse, institutionalization. Although living with an abuser is difficult, abused older adults often consider the known situation, and the ability to continue living in their own home, a preferable alternative to institutional care.

Because individual state laws concerning abuse reporting vary, it is important that counselors become familiar with the applicable laws in their own state and community. Community resources, such as adult protective services and ombudsman programs, should be readily available to a counselor. In addition, advocacy groups at the local, state, and national levels that act on behalf of older persons can be important resources for the older person and for the counselor. Some long-term care facilities offer respite care rooms in which older adults can reside for a few days or a week while family members are being assessed and treatment initiated to stop abusive situations. A major advantage of respite care is that it provides firsthand knowledge to the older individual of an alternate and more health-promoting care setting. Such contact can be a first step in helping the older person move toward a living arrangement that protects their dignity and restores their well-being.

Both individual and group interventions may be needed with older adults as well as their caregivers. At present, few formalized guidelines or programs for such intervention exist. As is true in most situations of family violence, few programs are available to treat perpetrators. Given the high level of cognitive and physical impairment that abused older adults experience, it is not surprising that few programs exist to provide counseling for this frail population. Interventions that empower the older individual, while providing for a secure and healthy living environment, offer the most potential for success (Myers, 1993). A case example may serve to illustrate the points here more clearly.

CASE EXAMPLE

A counselor working with an older person who lives with his daughter's family learns, during the course of counseling, that the older person has developed bed sores that need treatment. The counselor also notices that the older person seems to have been losing a significant amount of weight over the course of the last month. When the counselor begins to question the client about these issues, the client reluctantly tells the counselor that sometimes his daughter gets so angry at him, she refuses to feed him. He is also quick to add that she works hard and is very tired after a day's work and that is why she is short-tempered and too tired to cook dinner for him. He also states that the bed sores have developed because he spends much of his day in bed, waiting for assistance to get up. Sometimes, he is left in his bed for 2 or 3 days in soiled adult diapers. Again, he says he understands this because his daughter is just too

tired to care for him after working and taking care of her own husband and children. The client is quick to tell the counselor not to address these concerns with his daughter because he is afraid she will "put him in a home" and "she is doing the best she can." What is the counselor's responsibility in this situation?

First, the counselor needs to work with the client to help him understand that there are resources available that may help his daughter provide better care for him, feel less tired, and be able to spend more quality time with him. The counselor can also help the client understand that he has the right to have his basic human needs met and that the counselor can work with the family to help ensure that everyone's needs are met. The counselor may then meet with the daughter to explore her feelings regarding her father's care and her feeling of being overburdened. It is important that the counselor be nonjudgmental and create a climate in which the daughter can feel safe discussing her frustrations. The counselor may then suggest referral to community services that can assist with home healthcare or homemaking needs to help provide the daughter with more support. The daughter may also be invited to counseling sessions with her father at which communication can be facilitated. The counselor may also teach the daughter more effective coping strategies to deal with her frustrations. In this way, the abusive situation can be ended and the relationship between the daughter and her father improved.

It is important that the counselor remember that patterns of abuse are often learned and repeated in families. Adult children who are caring for dependent parents may simply be responding to the parent as the parent responded to them as children. It is imperative that the counselor help the family identify these patterns of abuse so that they can be stopped and replaced with more effective coping strategies. When the abusive situation cannot be ended, it is the counselor's responsibility to advocate for the client and to assist the client in finding a safe place to live and receive care.

OLDER ADULTS WITH A TERMINAL ILLNESS

A third subpopulation of AADA who may be inadequately served by the ACA ethical standards is the subpopulation of the terminally ill. The right-to-die and physician-assisted suicide issues are prominent in the popular press today. Medical technology has greatly advanced over the past few decades, making many terminal illnesses more chronic in nature (Marzuk, 1994). Because current medical technology makes it more difficult to classify specific illnesses or diseases as terminal, Marzuk recommended considering an illness terminal if life expectancy is less than 1 year. In recent years, court cases have supported the terminally ill patient's desire to avoid unwanted invasive medical treatment (Wanzer et al., 1989). However, fears of litigation and legal liability have sometimes resulted in physicians attempting to sustain life despite the presence of a living will or other advance directives for medical care (Westman, Lewandowski, & Proctor, 1993).

Terminally ill patients who desire to avoid further medical treatment have other options than the advance directives for medical care. Suicide and physician-assisted suicide are two choices that have received a great deal of media attention, particularly the physician-assisted suicide cases involving Jack Kevorkian and his suicide machine (Hooyman & Kiyak, 1993; Marzuk, 1994). The Oregon Death with Dignity Act, first passed in 1994 and upheld in a 1997 referendum, allows a physician to issue a lethal prescription to a terminally ill Oregon resident under a very strict set of circumstances. A legal injunction against implementation of this law is still in place, however (Cain, 1997).

Counselors, as mental health professionals, may become involved in counseling terminally ill patients (Fallowfield & Roberts, 1992). Some of these patients may express the desire to end their suffering by committing suicide. Assessing suicidal risk in terminally ill patients presents particular challenges (Marzuk, 1994). For example, preoccupation with dying or realistic planning for death may not be a true indicator of suicidal intention for terminally ill patients (Marzuk, 1994). Marzuk stated, "Many characteristics of terminally ill patients are independent risk factors for suicide in their own right" (p. 501). Some of these characteristics include depression, anxiety, delirium, hopelessness, pain and deterioration, and social isolation (Perry, 1990). Marzuk recommended nonjudgmental exploration of the terminally ill patient's suicidal intent as the first step in reducing suicidal risk. Other recommended steps included crisis intervention techniques, medication changes focused on reducing physical and emotional discomforts, and advocacy efforts for relieving social and financial stressors (Marzuk, 1994).

If a client reveals to the counselor a suicide plan to end his or her pain from a terminal illness, should the client's confidentiality be violated and should the counselor take steps to prevent the client from carrying out the suicide? The ACA standards (Herlihy & Corey, 1996) seem to expect the counselor to break confidentiality because the client is threatening harm to himself or herself. The standards seem clear, but should they apply equally in states with physician-assisted suicide laws? Furthermore, should they apply equally to older adults who have lived long and full lives and who are now making an informed choice to end their lives due to terminal conditions that cause intolerable pain and deterioration? The ACA standards also state that the counselor should endeavor to keep his or her own values from interfering with the counseling relationship. How does the counselor keep his or her values from interfering with a terminally ill person's wish for or right to die?

CASE EXAMPLE

Consider a case in which an 89-year-old woman comes for counseling after the diagnosis of advanced and inoperable bone cancer. She is in extreme pain and states she had decided to end her life by taking an overdose of pain medication prescribed by her physician. She states she has had a

long and productive life and does not wish to continue to endure the pain and the deteriorating condition of her body, just waiting to die. She states she is choosing to end her life as she has lived it, with dignity. Her purpose in coming to counseling is to make her last wishes known. She has no living family. She seems to be mentally competent. What is the counselor's responsibility?

Before a counselor can address this situation, the counselor must first explore his or her own beliefs regarding suicide and the right to die. The counselor must consider questions such as the following:

- Do counselors have the responsibility and the right to forcefully protect people from harm, even when the person is making an informed choice?
- Do counselors have the right to stop clients who have clearly chosen death over life?
- What are the legal and ethical considerations of right-to-die decisions?
- How do the factors of client age, client illness, client competence, and client choice affect the counselor's actions? (Corey, Corey, & Callanan, 1993)

Kirchberg and Neimeyer (1991) studied the degree of comfort 81 beginning counselors indicated for 15 counseling scenarios, 5 of which involved death or loss. They found that client problems dealing with death, suicide, and loss generated considerable discomfort for the novice mental health professional. In particular, they noted, "Indeed, it was striking that several of these death-related situations displaced such profound clinical complaints as incestuous abuse, rape, physical abuse, and alcoholism in the distress they triggered in these beginning counselors" (Kirchberg & Neimeyer, 1991, p. 608). The authors concluded that additional research was needed to determine the training and continuing education needs of counselors as related to dealing with situations involving death and dying. Even as this article is being written, the courts are grappling with the issue of assisted suicide and the right to die. What does seem to be clear is the client's right to refuse treatment. The counselor's duty to promote the best interests of the client and preserve client dignity might be interpreted to suggest that the counselor allow the client to make an informed choice to die with dignity. Without clear legal and ethical standards directly applicable to the situation, such as the one previously described, it is the counselor's obligation to be informed of legal and ethical guidelines that may exist in his or her own state at the time and to have completed a self-assessment of his or her own position on the issue in order to support the best interests of the client.

CONCLUSION

After a review of the current literature, we identified three areas involving counseling older adults for which few or inadequate ethical guidelines currently exist. These areas include the unique needs of older adults who have cogni-

tive impairments, victims of abuse, and those with a terminal illness. A model for ethical decision making was proposed, and guidelines for counselors working with clients in these three areas were identified. The case examples following each area of discussion demonstrate the direct application of these strategies.

Although this article could not possibly address every situation involving ethical dilemmas faced by counselors working with older adults, we hope that the guidelines and strategies will provide guidance for counselors in areas in which few or no guidelines currently exist. Counselors working with older adults may wish to include references to the ethical principles defined by Fitting (1986) in their declaration statements. This may help older clients to understand the importance of autonomy, beneficence, and fidelity in the counseling relationship.

As the population continues to age and new legislation is developed, new ethical dilemmas may occur for which no ethical guidelines exist or for which the ethical guidelines may change. Therefore, it is critical that counselors working with older adults stay abreast of the current issues, trends, and legislation related to counseling older adults and that counselors understand the impact these changes may have on ethical counseling with this population.

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